Attachment 4.19B,
Methods & Standards
For Establishing
Payment Rates,
Service 12.d,
Eyeglasses

MONTANA

I. Reimbursement for eyeglasses is through a single volume purchase contract issued by the Department through the competitive Request for Proposal process.

II. Reimbursement for medically necessary contact lenses is not included in the volume purchase contract for eyeglasses and is reimbursed as follows:

A. The lower of:

1. The provider's usual and customary charge; or
2. The Department's fee schedule.

III. The Department's fee schedule is determined by:

A. Establishing a fee for each new service which has been billed at least 50 time by all providers in the aggregate during the previous 12 month period. The Department shall set each fee at 90% of the average charge billed by all providers in the aggregate.

B. Once a fee has been established, the Department will not adjust that fee except as allowed by increased funding through the state's legislative process.

MONTANA

Reimbursement for Other Diagnostic Services

I. Reimbursement for Other Diagnostic Services shall be the lowest of the following:

A. For physicians, those fees provided and reimbursed for under Attachment 4.19B Methods & Standards for Establishing Payment Rates for Service 5 A Physician Services;

B. For mid-level practitioners, those fees provided and reimbursed for under Attachment 4.19B Methods & Standards for Establishing Payment Rates for Service 6(d) Other Practitioner Services;

C. For those other than specified in A and B above, the lowest of the following:

1. The provider's actual (submitted) charge for the service;
2. The amount allowable for the same service under Medicare (if covered by Medicare); or
3. The Department's fee schedule.

MONTANA

Reimbursement for Other Diagnostic Services

II. The Department's Fee is calculated as follows:

A. Specific Fee per Selected Procedure:

Any procedure exceeding 50 occurrences within a 12 month period will have a specific reimbursement fee established. This fee setting methodology applies to newly established procedures identified through annual changes to the HCPCS/CPT-IV procedure codes; or, procedures which have been paid at 65.2% of the billed charges in which 50 billing occurrences had not previously existed.

The reimbursement fee will be determined after 50 billing occurrences within a 12 month period. The fee will be established at 65.2% of the billed charges for the specific procedure. Once the fee is established, any increase in reimbursement must be authorized through legislature.

B. Percent of Billed Charges per Selected Procedure:

Procedures which are new procedures as identified through the annual HCPCS/CPT-IV coding changes are reimbursed at 65.2% of billed charges.

The fees in the Department's Other Diagnostic Services fee schedule for services provided by physicians or mid-level practitioners may not exceed the fees available for those services set forth in Attachment 4.19B Methods & Standards for Establishing Payment Rates for Service 5 A Physician Services or Attachment 4.19B Methods & Standards for Establishing Payment Rates for Service 6(d) Other Practitioner Services.

MONTANA

Reimbursement for Other Screening Services

I. Reimbursement for Other Screening Services shall be the lowest of the following:

A. For physicians, those fees provided and reimbursed for under Attachment 4.19B Methods & Standards for Establishing Payment Rates for Service 5 A Physician Services;

B. For mid-level practitioners, those fees provided and reimbursed for under Attachment 4.19B Methods & Standards for Establishing Payment Rates for Service 6(d) Other Practitioner Services;

C. For those other than specified in A and B above, the lowest of the following:

1. The provider's actual (submitted) charge for the service;
2. The amount allowable for the same service under Medicare (if covered by Medicare); or
3. The Department's fee schedule.

MONTANA

Reimbursement for Other Screening Services

II. The Department's Fee is calculated as follows:

A. Specific Fee per Selected Procedure:

Any procedure exceeding 50 occurrences within a 12 month period will have a specific reimbursement fee established. This fee setting methodology applies to newly established procedures identified through annual changes to the HCPCS/CPT-IV procedure codes; or, procedures which have been paid at 65.2% of the billed charges in which 50 billing occurrences had not previously existed.

The reimbursement fee will be determined after 50 billing occurrences within a 12 month period. The fee will be established at 65.2% of the billed charges for the specific procedure. Once the fee is established, any increase in reimbursement must be authorized through legislature.

B. Percent of Billed Charges per Selected Procedure:

Procedures which are new procedures as identified through the annual HCPCS/CPT-IV coding changes are reimbursed at 65.2% of billed charges.

The fees in the Department's Other Screening Services fee schedule for services provided by physicians or mid-level practitioners may not exceed the fees available for those services set forth in Attachment 4.19B Methods & Standards for Establishing Payment Rates for Service 5 A Physician Services or Attachment 4.19B Methods & Standards for Establishing Payment Rates for Service 6(d) Other Practitioner Services.

MONTANA

Reimbursement for Other Preventive Services

II. The Department's Fee is calculated as follows:

A. Specific Fee per Selected Procedure:

Any procedure exceeding 50 occurrences within a 12 month period will have a specific reimbursement fee established. This fee setting methodology applies to newly established procedures identified through annual changes to the HCPCS/CPT-IV procedure codes; or, procedures which have been paid at 65.2% of the billed charges in which 50 billing occurrences had not previously existed.

The reimbursement fee will be determined after 50 billing occurrences within a 12 month period. The fee will be established at 65.2% of the billed charges for the specific procedure. Once the fee is established, any increase in reimbursement must be authorized through legislature.

B. Percent of Billed Charges per Selected Procedure:

Procedures which are new procedures as identified through the annual HCPCS/CPT-IV coding changes are reimbursed at 65.2% of billed charges.

The fees in the Department's Other Preventive Services fee schedule for services provided by physicians or mid-level practitioners may not exceed the fees available for those services set forth in Attachment 4.19B Methods & Standards for Establishing Payment Rates for Service 5 A Physician Services or Attachment 4.19B Methods & Standards for Establishing Payment Rates for Service 6(d) Other Practitioner Services.

MONTANA

Reimbursement for Other Preventative Services

I. Reimbursement for Other Preventative Services shall be the lowest of the following:

A. For physicians, those fees provided and reimbursed for under Attachment 4.19B Methods & Standards for Establishing Payment Rates for Service 5 A Physician Services;

B. For mid-level practitioners, those fees provided and reimbursed for under Attachment 4.19B Methods & Standards for Establishing Payment Rates for Service 6(d) Other Practitioner Services;

C. For those other than specified in A and B above, the lowest of the following:

1. The provider's actual (submitted) charge for the service;
2. The amount allowable for the same service under Medicare (if covered by Medicare); or
3. The Department's fee schedule.

MONTANA

Reimbursement for Other Rehabilitative Services

I. Reimbursement for Other Rehabilitative Services shall be the lowest of the following:

A. For physicians, those fees provided and reimbursed for under Attachment 4.19B Methods & Standards for Establishing Payment Rates for Service 5 A Physician Services;

B. For mid-level practitioners, those fees provided and reimbursed for under Attachment 4.19B Methods & Standards for Establishing Payment Rates for Service 6(d) Other Practitioner Services;

C. For those other than specified in A and B above, the lowest of the following:

1. The provider's actual (submitted) charge for the service;
2. The amount allowable for the same service under Medicare (if covered by Medicare); or
3. The Department's fee schedule.

MONTANA

Reimbursement for Other Rehabilitative Services

II. The Department's Fee is calculated as follows:

A. Specific Fee per Selected Procedure:

Any procedure exceeding 50 occurrences within a 12 month period will have a specific reimbursement fee established. This fee setting methodology applies to newly established procedures identified through annual changes to the HCPCS/CPT-IV procedure codes; or, procedures which have been paid at 65.2% of the billed charges in which 50 billing occurrences had not previously existed.

The reimbursement fee will be determined after 50 billing occurrences within a 12 month period. The fee will be established at 65.2% of the billed charges for the specific procedure. Once the fee is established, any increase in reimbursement must be authorized through legislature.

B. Percent of Billed Charges per Selected Procedure:

Procedures which are new procedures as identified through the annual HCPCS/CPT-IV coding changes are reimbursed at 65.2% of billed charges.

The fees in the Department's Other Rehabilitative Services fee schedule for services provided by physicians or mid-level practitioners may not exceed the fees available for those services set forth in Attachment 4.19B Methods & Standards for Establishing Payment Rates for Service 5 A Physician Services or Attachment 4.19B Methods & Standards for Establishing Payment Rates for Service 6(d) Other Practitioner Services.

Service 17
Nurse Midwife
Services

MONTANA

Montana Medicaid applies the generic term Mid-level Practitioner to physician assistants and advanced practice nurses. Advanced practice nurses include certified nurse midwife, nurse anesthetist, nurse practitioner, etc.

I. Reimbursement for Mid-level Practitioners' Services for immunizations; family planning; radiology; pathology and laboratory and cardiography and echocardiography services; services billed under HCPCS J codes; and, for EPSDT services shall be the lower of:

   A. The provider's usual and customary charge for the service; or

   B. Those fees provided and reimbursed for under Attachment 4.19B, Methods & Standards for Establishing Payment Rates for Service 5(a), Physicians' Services.

II. Reimbursement for all Mid-level Practitioners' Services not listed in I. above shall be the lower of:

   A. The provider's usual and customary charge for the service; or

   B. 90% of those fees provided and reimbursed for under Attachment 4.19B, Methods & Standards for Establishing Payment Rates for Service 5(a), Physicians' Services.